Confidentiality in Psychiatry and Psychotherapy

WILLIAM G. CLOSSON, JR., M.D., ROBERT A. HALL, M.D., AND BERTHA S. MASON, M.D., *San Jose*

CONFIDENTIALITY HAS long been accepted and assumed by both physician and patient in their relationship and is an essential principle in the Code of Medical Ethics. Since confidentiality has special meaning in psychotherapy the American Psychiatric Association in 1962 drew up and ratified the following amplification:

"Confidentiality may be defined as an ethical understanding between the physician and the patient that anything the patient tells his doctor will not be divulged to anyone else. The principle has governed physician-patient relationships since time immemorial and is as sound today as ever. In the case of psychiatry, *it is absolutely essential to the practice of psychotherapy* since, obviously, patients would not reveal their thoughts and feelings if it were not observed. Confidentiality, however, like freedom, is not quite absolute. The physician, like everyone else, is subject to laws which may, under certain circumstances, require a breach of the rule of confidentiality. Even then, however, there are certain legal procedures which must be scrupulously followed. In addition, there is a vaguer area in which the physician must in the last analysis turn only to God and his own conscience for guidance as when an act harmful to the patient and society might be committed if strict confidentiality were to be maintained. The rare exception, however, only reinforces the time-honored rule."

There is now an urgent need to further clarify and amplify this basic statement because of the inroads being made into the practice of confidentiality by increasing requests for disclosure of information.

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Reprint requests to: The Psychiatric Medical Group, Inc., 1120 McKendrie Street, San Jose, Ca. 95126 (Dr. W. G. Closson, Jr.)

The basic statement by the American Psychiatric Association implies two conditions underlying the importance of confidentiality.

1. The physician or pyschotherapist honors the integrity of the patient as an individual.

2. The patient trusts the physician and in order to obtain help is willing to reveal all information essential to diagnosis and treatment. This includes facts which are actually or potentially socially damaging.

These two conditions apply to all physician-patient relationships but in psychotherapy they are, as the statement says, "absolutely essential": A breach of confidentiality undermines the dignity of the individual and threatens the flow of intimate private facts, frequently important to the therapeutic process and its outcome.

Further, the nature of the disclosures which the physician may not make are clearly set forth in the American Medical Association statement of confidentiality.

1. "The confidences entrusted to him in the course of medical attendance."

2. "The deficiencies he may observe in the character of patients."

Since psychiatry and psychotherapy are fundamentally concerned with the treatment of so-called "deficiencies in the character," revealing *any* information as to diagnosis, observations or progress is a disclosure of what the psychotherapist has observed or concluded and is a breach of confidentiality no less than the disclosure of the most sensitive private confidences.

Two aspects of confidentiality in psychotherapy call for greater awareness on the part of therapists, and the public:

1. The extent of information which must re-

main confidential as compared with medical practice in general.

2. The unique and vital importance of confidentiality in psychotherapy.

In psychotherapy it is essentially *everything* that transpires during treatment that must be guarded as confidential – all the private information, feelings, dreams, fantasies of the patient, *and* all observations, inferences, conclusions, diagnoses and advice of the therapist. On the other hand in the general practice of medicine and in other specialties much that transpires during medical care is *not* confidential. In practices of that kind, it is only "confidences entrusted to the physician" and certain kinds of observations about the personality of the patient that must be so guarded. It is important for therapists to become aware of this distinction and recognize that the pattern of ethical practice that is representative of the larger professional body must be modified in order to be appropriate.

Confidentiality creates the protective situation in which the patient with the help of the psychotherapist can face, accept, and work to overcome or correct the deficiencies and distortions which have caused serious difficulties in his life. Without this protective situation which the strict practice of confidentiality creates and assures, changes, corrections and developments are not as likely to take place. It is the disclosure itself and, perhaps more important, the threat of possible disclosure, which will erode and damage the protective situation essential to effective therapy.

The patient comes to the therapist for the treatment of his emotional, mental, or personality difficulties. Since it is the therapist who takes the responsibility for this treatment, he can and should also assume the responsibility to zealously guard against disclosure.

Patient's Consent to Disclosure

What, then, about the practice of disclosing confidential information by the psychiatrist when the patient has signed a "release"? It is our belief that the patient's consent is a prerequisite to disclosure (except in emergencies) but not in itself reason for disclosure. It is the psychotherapist who is responsible for treatment and it is the psychotherapist, not the patient, who is governed by the rule of confidentiality.

It may be argued that the therapist should accede to the disclosure since the patient wants it. Acceding to a desire or demand of the patient can be a detriment to his treatment. The patient's demand for disclosure may have been made more or less under overt or implied duress.

There are patients in whose cases disclosure would do no harm. Yet selective decisions on disclosure would inevitably lead to negative and damaging implications with regard to all patients about whom disclosure is denied. Those problems centering around the agency requesting information require a solution, the first step of which is to make these agencies and the public in general aware of the nature of confidentiality in psychotherapy. Still other ways must be found to handle these matters without jeopardizing confidentiality. In our experience one solution has been to suggest an examination be conducted by another psychiatrist who is not involved in the patient's treatment.

A psychiatrist engaged as an examiner outside the treatment situation is not in a therapist-patient relationship and can be expected to be a source of information. The patient is not under any misconception that he is there for therapeutic reasons; he understands the legal or business basis for the examination.

Breach of Confidentiality

It appears to us that disclosure of confidential psychiatric information should be limited to three basic situations:

1. *Treatment.* With consent of the patient full information should be disclosed to any bonafide practitioner or clinic who needs such information for direct treatment, or consultation about treatment. Consultation can be considered an extension of the treatment situation.

2. *Research.* Research in psychiatry and psychotherapy must frequently utilize the confidential information of patients as well as observations and conclusions of the therapist; however, preservation of confidentiality can be partially attained by rigorously maintaining anonymity.

3. *Emergencies.* With or without consent of the patient, disclosure seems ethically defensible when it is necessary to avoid highly probable, imminent and serious harm to the patient or others, and when the therapist is the only reasonable source of such confidential information.

Clear-cut expectation of suicide or homicide presents such a situation. Another instance would be participation by the therapist in legal commitment necessary to avoid the patient's death or probable physical or mental deterioration.

Many demands are being made on psychotherapists nowadays for disclosure of confidential information to agencies and organizations which do not fall within any of the conditions mentioned above—employers, federal and state investigative agencies, courts and probation agencies, insurance carriers, administrators of governmental welfare programs, including Social Security, Medi-Cal, Medi-Care, and physicians, including psychiatrists, who are acting in an investigational capacity for any of the foregoing.

Problems of Refusal of Requests

Some problems resulting from our experience of several years in practicing the ethic of confidentiality will be mentioned. Either the patient or the proposed recipient of information, or both, may maintain that disclosure is necessary for action regarding such matters as claims, justice, employment or reemployment decisions, security clearance and the like. Those problems arising with the patient can be dealt with within the therapeutic process—and often will contribute to treatment program. In addition, the very act of refusal to disclose information will have for some patients a very significant therapeutic effect, especially in those "weak ego" patients who least expect to be treated with individual dignity.

Security Clearances. All such requests for information on patients formerly or actively under treatment are answered by letter which gives our stated policy. On several occasions, after receiving our letter, members of the agency have visited us personally and requested the information. It became clear in some cases that these individuals merely collected such information and passed it along to their superiors. They admitted they did not know who would evaluate the material nor how the evaluation would be used. When these men were asked how they would feel if they were in the patient's shoes and would they want information released if they were in treatment, we were surprised and gratified to hear some of them say unofficially that they would respect and admire our stand.

Recently we had a case which would seem to confirm our feeling that our position is therapeutically and basically sound. A patient, aged 26, had been in treatment for ten months and although he had made 36 visits we felt that he had never become involved in treatment. In the summer he went on Active Reserve military duty and we received from the Army a release, signed by the patient, authorizing disclosure of information concerning the patient. We refused. The Army persisted in its request for information, stating that the patient might be hurt by our refusal to give this information. The patient also called and asked us to go ahead and give the information. However, we refused and apparently he was dropped from the Active Reserve. If this is so, we consider this an unfair harassment and punishment. A few months later the patient unexpectedly entered into intensive and more productive therapy.

Insurance Company—Major Medical Policies. We indicate on these forms that the patient has an emotional disorder, and usually this is sufficient. Some companies, however, request American Psychiatric Association diagnosis along with a more detailed request for information, such as patient's difficulties in interpersonal relationships, work relationships and marital relationships, as well as treatment plans and prognosis. In several cases, the insurance companies refused payment unless these demands were complied with. Resolution, with honoring of claims for psychotherapy with us, has usually occurred when the company followed our suggestion that another psychiatrist, not party to the treatment, be employed to examine the patient and to act, in essence, as an investigative agent.

Life Insurance Companies. We have been declining requests for information from life insurance companies regarding patients previously or actively in treatment. Our statement of policy has caused little difficulty here. The insurance company has on some occasions had the patient examined by its own psychiatrist.

Employers. The problem here is that the employer often seems to be trying to be helpful to the employee. In one such case the patient had had two previous breakdowns and the employer's stated concern was as to how much stress and responsibility the patient could be expected to take. After discussion with his boss, the company had him evaluated by another psychiatrist.

One patient objected to our policy because she

felt that the treating psychiatrist would give her a good job recommendation. In this case, to have done so the treating psychiatrist would have had to conceal or distort damaging facts. In this case the policy helped the treating doctor avoid what might have become a difficult counter-transference problem.

Federal Civil Service. Recently a patient applied for a job and we received a signed release for medical information. When this was refused and referral to another physician suggested, the patient was told it was her responsibility to provide medical records. When the patient offered to have an examination done by another doctor, at her own expense, the offer was refused and her job application turned down.

Summary and Conclusions

In conclusion we propose:

That there is need for increased vigilance toward the safeguarding of confidentiality in psychiatry and psychotherapy.

That the professional ethic on confidentiality for psychiatrists and allied professionals should be clarified and expanded to include the following points.

1. In the practice of psychiatry and psychotherapy confidential information includes all observation, inferences, conclusions, diagnoses, and advice given as well as all private information revealed by the patient.

2. It is the responsibility of the psychotherapist to maintain the confidentiality even though the patient, more or less under duress, may have given consent for disclosure.

3. Disclosure of confidential information should be strictly limited to the following conditions: (1) where it is needed by a physician, psychotherapist, or clinic for treatment of the patient, (2) consultation, (3) research when anonymity can be maintained, and (4) when disclosure is necessary to forestall a serious, imminent, and clear-cut threat to the safety of the patient or others.

We propose that the statement of ethical position on confidentiality of the American Psychiatric Association and of organizations of allied professionals be modified to incorporate these principles.